FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042176

Facility Name: RENAISSANCE AT HILLSIDE

Address: 4600 FRONTAGE ROAD (Number) HILLSIDE (City) 60162 (Zip Code)

County: COOK

Telephone Number: (708) 544-9933 **Fax #** (708) 544-9966

IDPA ID Number: 363980624001

Date of Initial License for Current Owners: 06/30/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) NOSHIR R. DARUWALLA, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 1/22/01

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	156	Skilled (SNF)	166	60,380	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	156	TOTALS	166	60,380	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	43,257	4,019	6,226	53,502	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,257	4,019	6,226	53,502	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.61%

D. How many bed-hold days during this year were paid by Public Aid?
534 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/30/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/30/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	312,000	76,559	6,266	394,825		394,825	(56,738)	338,087			1
2	Food Purchase		276,709		276,709		276,709	(41,674)	235,035			2
3	Housekeeping	274,233	40,337	152	314,722		314,722	(42,917)	271,805			3
4	Laundry		19,819		19,819		19,819		19,819			4
5	Heat and Other Utilities			157,202	157,202		157,202	(54,134)	103,068			5
6	Maintenance	55,092	43,427	73,527	172,046		172,046	(22,205)	149,841			6
7	Other (specify):*							23	23			7
8	**TOTAL General Services**	641,325	456,851	237,147	1,335,323		1,335,323	(217,644)	1,117,679			8
	B. Health Care and Programs											
9	Medical Director			32,550	32,550		32,550		32,550			9
10	Nursing and Medical Records	1,756,463	145,742	104,450	2,006,655		2,006,655	652	2,007,307			10
10a	Therapy	41,396		1,860	43,256		43,256		43,256			10a
11	Activities	96,039	23,048	4,164	123,251		123,251		123,251			11
12	Social Services	49,573		3,137	52,710		52,710		52,710			12
13	Nurse Aide Training	4,757	461	2,850	8,068		8,068		8,068			13
14	Program Transportation			1,985	1,985		1,985	270	2,255			14
15	Other (specify):*							53	53			15
16	**TOTAL Health Care and Programs**	1,948,228	169,251	150,996	2,268,475		2,268,475	975	2,269,450			16
	C. General Administration											
17	Administrative	184,662		488,774	673,436		673,436	(254,303)	419,133			17
18	Directors Fees											18
19	Professional Services			61,641	61,641	(3,206)	58,435	(1,085)	57,350			19
20	Dues, Fees, Subscriptions & Promotions			127,231	127,231		127,231	(74,260)	52,971			20
21	Clerical & General Office Expenses	245,079	42,955	123,347	411,381		411,381	25,824	437,205			21
22	Employee Benefits & Payroll Taxes			564,616	564,616		564,616	(27,500)	537,116			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,141	9,141		9,141	(5,126)	4,015			24
25	Other Admin. Staff Transportation			1,256	1,256		1,256	250	1,506			25
26	Insurance-Prop.Liab.Malpractice			177,252	177,252		177,252	(12,306)	164,946			26
27	Other (specify):*							24,451	24,451			27
28	**TOTAL General Administration**	429,741	42,955	1,553,258	2,025,954	(3,206)	2,022,748	(324,054)	1,698,694			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,019,294	669,057	1,941,401	5,629,752	(3,206)	5,626,546	(540,724)	5,085,822			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number RENAISSANCE AT HILLSIDE #0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			105,504	105,504		105,504	168,013	273,517			30
31	Amortization of Pre-Op. & Org.							30,781	30,781			31
32	Interest			176,381	176,381		176,381	556,862	733,243			32
33	Real Estate Taxes			260,221	260,221	3,206	263,427	(3,304)	260,123			33
34	Rent-Facility & Grounds			1,008,743	1,008,743		1,008,743	(1,000,290)	8,453			34
35	Rent-Equipment & Vehicles			19,071	19,071		19,071	6,370	25,441			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,569,920	1,569,920	3,206	1,573,126	(241,568)	1,331,558			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	9,663	67,273	309,033	385,969		385,969	(3,346)	382,623			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			90,570	90,570		90,570		90,570			42
43	Other (specify):*	39,217			39,217		39,217	(39,217)				43
44	**TOTAL Special Cost Centers**	48,880	67,273	399,603	515,756		515,756	(42,563)	473,193			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,068,174	736,330	3,910,924	7,715,428		7,715,428	(824,854)	6,890,574			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

STATE OF ILLINOIS

RENAISSANCE AT HILLSIDE

ID# 0042176

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PART B COINS W/O -OT	$ (6,610)	21	1
2	PART B COINS W/O -PT	(7,800)	21	2
3	PART B COINS W/O -ST	(2,818)	21	3
4	CABLE	(11,369)	05	4
5	BANK CHARGES	(1,531)	21	5
6	BUILDING PARTNERSHIP TRUST FEES	(920)	20	6
7	BLDG PARTNERSHIP PROFESSIONAL FEES	(7,382)	19	7
8				8
9	MISSING LEGAL INVOICE	(634)	19	9
10	REAL ESTATE TAX - SLF / DAY CARE	(3,304)	33	10
11	BUILDING P'SHIP MGMT FEES	(37,912)	17	11
12	BUILDING P'SHIP STATE INCOME TAXES	(785)	21	12
13	JURY DUTY INCOME	(17)	21	13
14	FOOD REBATES	(1,690)	2	14
15	COPIES	(140)	21	15
16	TV RENT	(335)	21	16
17	CABLE	(475)	5	17
18	AT&T	(4)	21	18
19	PRIOR PERIOD PHARMACY EXPENSE	(3,376)	39	19
20	MARKETING SALARY	(39,217)	43	20
21	BUILDING PARTNERSHIP-BANK CHARGES	(7)	21	21
22	OUT OF PERIOD SEMINAR EXPENSE	(383)	24	22
23	PRIOR PERIOD LEGAL FEES	(85)	19	23
24	POLITICAL CONTRIBUTIONS - ICLTC	(1,144)	20	24
25	COLLECTIONS	(2,142)	19	25
26				26
27				27
28				28
29				29
30				30
31				31
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96				96
97				97
98				98
99				99
100				100
	Total	(130,081)		

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(95,084)	30		9
10	Interest and Other Investment Income	(8,255)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(208)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,536)	21		18
19	Entertainment	(5,831)	24		19
20	Contributions	(16,225)	20		20
21	Owner or Key-Man Insurance	(27,500)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	21		24
25	Fund Raising, Advertising and Promotional	(54,901)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(9,024)	20		28
29	Other-Attach Schedule	(130,081)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (413,645)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(411,210)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (411,210)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (824,854)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			18				(56,756)					(56,738)	1
2	Food Purchase	(1,898)						(39,777)					(41,674)	2
3	Housekeeping							(42,917)					(42,917)	3
4	Laundry													4
5	Heat and Other Utilities	(11,844)		584				(42,874)					(54,134)	5
6	Maintenance			1,256				(23,461)					(22,205)	6
7	Other (specify):*			23									23	7
8	**TOTAL General Services**	(13,742)		1,881				(205,784)					(217,644)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			652									652	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation			270									270	14
15	Other (specify):*			53									53	15
16	**TOTAL Health Care and Programs**			975									975	16
	C. General Administration													
17	Administrative	(37,912)	37,912	1,225	(125,946)	(111,698)	(17,884)						(254,303)	17
18	Directors Fees													18
19	Professional Services	(10,243)	7,382	974			802						(1,085)	19
20	Fees, Subscriptions & Promotions	(82,214)	920	544			6,490						(74,260)	20
21	Clerical & General Office Expenses	(86,584)	792	121,289		257	2,023	(11,953)					25,824	21
22	Employee Benefits & Payroll Taxes	(27,500)											(27,500)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(6,214)		1,064			24						(5,126)	24
25	Other Admin. Staff Transportation			250									250	25
26	Insurance-Prop.Liab.Malpractice			434				(12,740)					(12,306)	26
27	Other (specify):*			17,877	2,195	371	4,008						24,451	27
28	**TOTAL General Administration**	(250,667)	47,006	143,657	(123,751)	(111,070)	(4,537)	(24,693)					(324,054)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(264,409)	47,006	146,513	(123,751)	(111,070)	(4,537)	(230,476)					(540,724)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(95,084)	259,317	3,780									168,013	30
31	Amortization of Pre-Op. & Org.		30,781										30,781	31
32	Interest	(8,255)	591,373	(2,189)				(24,067)					556,862	32
33	Real Estate Taxes	(3,304)											(3,304)	33
34	Rent-Facility & Grounds		(1,008,743)	8,453									(1,000,290)	34
35	Rent-Equipment & Vehicles			6,370									6,370	35
36	Other (specify):*													36
37	TOTAL Ownership	(106,643)	(127,272)	16,414				(24,067)					(241,568)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(3,376)		30									(3,346)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(39,217)											(39,217)	43
44	TOTAL Special Cost Centers	(42,593)		30									(42,563)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(413,645)	(80,266)	162,957	(123,751)	(111,070)	(4,537)	(254,543)					(824,854)	45

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Hillside Limited Partnership		
				Building Partnership		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,008,743	Hillside Limited Partnership		$	$ (1,008,743)	1
2	V	31	Amortization		Hillside Limited Partnership		30,781	30,781	2
3	V	30	Depreciation		Hillside Limited Partnership		259,317	259,317	3
4	V	20	Trust Fees		Hillside Limited Partnership		920	920	4
5	V	19	Professional Fees		Hillside Limited Partnership		7,382	7,382	5
6	V	32	Interest Expense		Hillside Limited Partnership		597,910	597,910	6
7	V	17	Management Fees		Hillside Limited Partnership		37,912	37,912	7
8	V	32	Interest Income	6,537	Hillside Limited Partnership			(6,537)	8
9	V	21	State Income Tax		Hillside Limited Partnership		785	785	9
10	V	21	Bank Charges		Hillside Limited Partnership		7	7	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,015,280			$ 935,014	$ * (80,266)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	NUCARE SERVICES CORP.	100.00%	$ 18	$ 18	15
16	V	5	UTILITIES		NUCARE SERVICES CORP.		584	584	16
17	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.		1,256	1,256	17
18	V	7	EMPLOYEE BEN. GEN. SERV.		NUCARE SERVICES CORP.		23	23	18
19	V	10	NURSING ADMIN. COMP.		NUCARE SERVICES CORP.		652	652	19
20	V	14	PROGRAM TRANSPORTATION		NUCARE SERVICES CORP.		270	270	20
21	V	15	HEALTHCARE BENEFITS		NUCARE SERVICES CORP.		53	53	21
22	V	17	ADMINISTRATIVE - NON-OWNER		NUCARE SERVICES CORP.		1,225	1,225	22
23	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.		974	974	23
24	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.		544	544	24
25	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.		121,289	121,289	25
26	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.		1,064	1,064	26
27	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.		250	250	27
28	V	26	INSURANCE		NUCARE SERVICES CORP.		434	434	28
29	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.		17,877	17,877	29
30	V	30	DEPRECIATION		NUCARE SERVICES CORP.		3,780	3,780	30
31	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.		(2,189)	(2,189)	31
32	V	34	BUILDING RENT		NUCARE SERVICES CORP.		8,453	8,453	32
33	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.		6,370	6,370	33
34	V	39	ANCILLARY		NUCARE SERVICES CORP.		30	30	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 162,957	$ * 162,957	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - R. HARTMAN	$	NUCARE SERVICES CORP.	100.00%	$ 64,651	$ 64,651	15
16	V	17	ADMIN. - B. CARR		NUCARE SERVICES CORP.		15,991	15,991	16
17	V	17	ADMIN. - D. HARTMAN		NUCARE SERVICES CORP.		1,446	1,446	17
18	V	17	ADMIN. - E. DICKMAN		NUCARE SERVICES CORP.				18
19	V	27	EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.		1,395	1,395	19
20	V	27	EMP. BEN. - B. CARR		NUCARE SERVICES CORP.		687	687	20
21	V	27	EMP. BEN. - D. HARTMAN		NUCARE SERVICES CORP.		113	113	21
22	V	27	EMP. BEN. - E. DICKMAN		NUCARE SERVICES CORP.				22
23	V								23
24	V								24
25	V	17	MANAGEMENT FEES	208,034	NUCARE SERVICES CORP	100.00%		(208,034)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 208,034			$ 84,283	$ * (123,751)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	J. RAJCHENBACH-COMP.	$	JLR MANAGEMENT CORP.	100.00%	$ 8,302	$ 8,302	15
16	V	21	OFFICE		JLR MANAGEMENT CORP.		257	257	16
17	V	27	PAYROLL TAXES				371	371	17
18	V								18
19	V								19
20	V								20
21	V	17	MARVIN NEEDLE-CONS. FEES		JRL MANAGEMENT CORP.	100.00%			21
22	V								22
23	V								23
24	V	17	MARK BERGER-CONS. FEES		JRL MANAGEMENT CORP.	100.00%			24
25	V	21	SECRETARIAL		JRL MANAGEMENT CORP.	100.00%			25
26	V								26
27	V								27
28	V								28
29	V	17	MANAGEMENT FEES	120,000	JRL MANAGEMENT CORP	100.00%		(120,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 120,000			$ 8,930	$ * (111,070)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	CAREPATH HEALTH NETWORK	100.00%	$ 22,856	$ 22,856	15
16	V	19	PROFESSIONAL FEES		CAREPATH HEALTH NETWORK		802	802	16
17	V	20	FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK		6,490	6,490	17
18	V	21	CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK		2,023	2,023	18
19	V	24	SEMINARS		CAREPATH HEALTH NETWORK		24	24	19
20	V	27	GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK		4,008	4,008	20
21	V								21
22	V								22
23	V								23
24	V	17	MANAGEMENT FEES	40,740	CAREPATH HEALTH NETWORK			(40,740)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 40,740			$ 36,203	$ * (4,537)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 56,756	HILLSIDE ASSISTED LIVING CENTER	100.00%	$	$ (56,756)	15
16	V	02	FOOD	39,777	HILLSIDE ASSISTED LIVING CENTER	100.00%		(39,777)	16
17	V	03	HOUSEKEEPING	42,917	HILLSIDE ASSISTED LIVING CENTER	100.00%		(42,917)	17
18	V	05	UTILITIES	42,874	HILLSIDE ASSISTED LIVING CENTER	100.00%		(42,874)	18
19	V	06	MAINTENANCE	23,461	HILLSIDE ASSISTED LIVING CENTER	100.00%		(23,461)	19
20	V	21	OFFICE	11,953	HILLSIDE ASSISTED LIVING CENTER	100.00%		(11,953)	20
21	V	26	INSURANCE	12,740	HILLSIDE ASSISTED LIVING CENTER	100.00%		(12,740)	21
22	V	32	INTEREST	24,067	HILLSIDE ASSISTED LIVING CENTER	100.00%		(24,067)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 254,543			$	$ * (254,543)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Worker's Compensation	$ 72,108	Diamond Insurance	40.00%	$ 72,108	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 72,108			$ 72,108	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Bernard Hollander	Owner	Administrative	25.00%	See Attached	2	3.08%		$		1
2	Jack Rajchenback	Owner	Administrative	25.00%	See Attached	3	4.61%	Alloc-Salary	8,302	17-7	2
3	Robert Hartman	Owner	Administrative	20.05%	See Attached	3.28	5.05%	Alloc-NuCare	64,651	17-7	3
4	Robert Hartman	Owner	Administrative	20.05%	See Attached			Mgmt Fees	120,000	17-3	4
5	David Hartman	Relative	Administrative		See Attached	.40	0.88%	Alloc-NuCare	1,446	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 194,399		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAIL. CENSUS DAYS	672,540	8	$ 205	$	60,380	$ 18	1
2	5	UTILITIES	AVAIL. CENSUS DAYS	672,540	8	6,508		60,380	584	2
3	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	672,540	8	13,988	1,054	60,380	1,256	3
4	7	EMPLOYEE BEN. GEN. SERV.	AVAIL. CENSUS DAYS	672,540	8	258		60,380	23	4
5	10	NURSING ADMIN. COMP.	AVAIL. CENSUS DAYS	672,540	8	7,261	2,431	60,380	652	5
6	14	PROGRAM TRANSPORTATION	AVAIL. CENSUS DAYS	672,540	8	3,009		60,380	270	6
7	15	HEALTHCARE BENEFITS	AVAIL. CENSUS DAYS	672,540	8	595		60,380	53	7
8	17	ADMINISTRATIVE - NON-OWN	AVAIL. CENSUS DAYS	672,540	8	13,648	8,000	60,380	1,225	8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	672,540	8	10,851		60,380	974	9
10	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	672,540	8	6,065		60,380	544	10
11	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	672,540	8	1,350,975	1,102,702	60,380	121,289	11
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	672,540	8	11,855		60,380	1,064	12
13	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	672,540	8	2,788		60,380	250	13
14	26	INSURANCE	AVAIL. CENSUS DAYS	672,540	8	4,831		60,380	434	14
15	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	672,540	8	199,124		60,380	17,877	15
16	30	DEPRECIATION	AVAIL. CENSUS DAYS	672,540	8	42,107		60,380	3,780	16
17	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	672,540	8	(24,377)		60,380	(2,189)	17
18	34	BUILDING RENT	AVAIL. CENSUS DAYS	672,540	8	94,150		60,380	8,453	18
19	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	672,540	8	70,953		60,380	6,370	19
20	39	ANCILLARY	AVAIL. CENSUS DAYS	672,540	8	335	269	60,380	30	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,815,129	$ 1,114,456		$ 162,957	25

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	36.52	8	720,115	720,000	3.28	64,651	1
2	17	ADMIN. - B. CARR	AVG. HOURS WORKED	40.00	8	177,679	175,000	3.60	15,991	2
3	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	5.00	8	18,073	17,000	0.40	1,446	3
4	17	ADMIN. - E. DICKMAN	AVG. HOURS WORKED	35.00	1	20,728	19,166			4
5	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	36.52	8	15,535		3.28	1,395	5
6	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	40.00	8	7,632		3.60	687	6
7	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	5.00	8	1,411		0.40	113	7
8	27	EMP. BEN. - E. DICKMAN	AVG. HOURS WORKED	35.00	1	1,576				8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 962,749	$ 931,166		$ 84,283	25

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: JLR MANAGEMENT CORP.
Street Address: 6633 NORTH LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	61	9	$ 168,808	$ 168,808	3	$ 8,302	1
2	21	OFFICE	AVG. HOURS WORKED	61	9	5,235		3	257	2
3	27	PAYROLL TAXES	AVG. HOURS WORKED	61	9	7,543		3	371	3
4										4
5										5
6										6
7	17	MARVIN NEEDLE-CONS. FEES	AVG. HOURS WORKED	40	1	36,296				7
8										8
9										9
10	17	MARK BERGER-CONS. FEES	AVG. HOURS WORKED	50	2	10,000				10
11	21	SECRETARIAL	AVG. HOURS WORKED	50	2	5,000				11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 232,882	$ 168,808		$ 8,930	25

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	629,760	13	$ 353,316	$ 353,316	40,740	$ 22,856	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	629,760	13	12,396		40,740	802	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	629,760	13	100,317		40,740	6,490	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	629,760	13	31,275		40,740	2,023	4
5	24	SEMINARS	CARE PATH FEES	629,760	13	366		40,740	24	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	629,760	13	61,960		40,740	4,008	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 559,630	$ 353,316		$ 36,203	25

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HILLSIDE ASSISTED LIVING CENTER
Street Address: 6677 N. LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	MEALS SERVED	187,452	2	$ 394,825	$ 312,000	26,946	$ 56,756	1
2	02	FOOD	MEALS SERVED	187,452	2	276,709		26,946	39,777	2
3	03	HOUSEKEEPING	SQUARE FEET	77,157	2	314,722	274,233	10,521	42,917	3
4	05	UTILITIES	SQUARE FEET	77,157	2	157,202		21,043	42,874	4
5	06	MAINTENANCE	SQUARE FEET	77,157	2	172,046	55,092	10,522	23,461	5
6	21	OFFICE	PATIENT DAYS	62,484	2	166,302		4,491	11,953	6
7	26	INSURANCE	PATIENT DAYS	62,484	2	177,252		4,491	12,740	7
8	32	INTEREST	DIRECT ALLOC						24,067	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,659,058	$ 641,325		$ 254,543	25

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Diamond Insurance
Street Address: 40 Skokie Blvd.
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847) 559-1002
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Workers Compensation	Direct Allocation			$	$		$ 72,108	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 72,108	25

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Cole Taylor Bank		X	Mortgage	$7,498,449		$	$ 7,498,449			$ 597,910	1
2	American Nat'l Bank		X	Line of Credit							115,528	2
3	Shareholder Loan	X						510,000			21,631	3
4	Deutche Financial Services		X					4,414			2,213	4
5												5
	Working Capital											
6	CIB Bank		X								18,778	6
7	Cole Taylor Bank		X								18,232	7
8												8
9	TOTAL Facility Related				$7,498,449		$	$ 8,012,863			$ 774,292	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(6,537)	10
11	Interest Income										(8,254)	11
12	Allocated From NuCare										(2,189)	12
13	Transfer of Interest Exp.			Assisted Living							(24,067)	13
14	TOTAL Non-Facility Related						$	$			$ (41,047)	14
15	TOTALS (line 9+line14)						$	$ 8,012,863			$ 733,245	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTEREST INCOME			BUILDING COMPANY			$	$			$ (6,537)	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (6,537)	21

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 383,645	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 238,450	2
3. Under or (over) accrual (line 2 minus line 1).		$ (145,195)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 402,112	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 3,206	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 260,123	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997	78,610	9
1998	313,908	10
1999	365,376	11
2000	382,965	12

REAL ESTATE TAX ACCRUAL=382964.52*1.05=402112.75

$144,515 of Real Estate tax expense was paid by Hillside Assisted Living and the Montessori Day Care Center.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME RENAISSANCE AT HILLSIDE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0042176

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-17-101-014-000	LONG TERM CARE PROPERTY	$ 382,965.00	$ 245,097.60
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 382,965.00	$ 245,097.60

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,306 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Hillside Assisted Living Center, Ltd. Assisted Living Center 27,945 Square Feet -Combined for Assisted Living and Child Day Care
Hillside Montessori School Child Day Care

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 124,111
2. Number of Years Over Which it is Being Amortized: 10
3. Current Period Amortization: 30,781
4. Dates Incurred: 01/01/97-06/30-97

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	87,678	1995	$ 586,500	1
2					2
3	TOTALS	87,678		$ 586,500	3

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1997	$ 6,595,748	$ 259,317	35	$ 188,450	$ (70,867)	$ 949,317	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1997	358,810		20	17,941	17,941	80,055	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		2,139	111		105	(6)	445	68
69	Financial Statement Depreciation			13,719			(13,719)		69
70	TOTAL (lines 4 thru 69)		$ 6,956,697	$ 273,147		$ 206,496	$ (66,651)	$ 1,029,817	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,956,697	$ 273,147		$ 206,496	$ (66,651)	$ 1,029,817	1
2	ROOF DISPLAY	1998	250		20	13	13	49	2
3	CANOPY	1998	1,000		20	50	50	183	3
4	FLAG POLE & FLAGS	1998	1,762		20	88	88	323	4
5	LUNCH ROOM	1998	5,983		20	299	299	1,071	5
6	LANDSCAPING	1998	5,079		20	254	254	910	6
7	AMP INSTALLATION	1998	1,822		20	91	91	341	7
8	CABLE & FACE PLATES	1998	1,404		20	70	70	251	8
9	BANNERS	1998	2,819		20	141	141	505	9
10	WANDERGUARD	1998	7,383		20	369	369	1,384	10
11	FENCE	1998	2,418		20	121	121	403	11
12	WALL & CORNER GUARDS	1998	4,369		20	218	218	672	12
13	SIGNS	1998	950		20	48	48	156	13
14	REWIRE CHILLER	1998	1,279		20	64	64	224	14
15	PAGING SYSTEM	1998	3,823		20	191	191	637	15
16	CARPET	1999	1,548		20	77	77	231	16
17	LIGHT FIXTURE	1999	1,099		20	55	55	165	17
18	AVONITE TOPS	1999	390		20	20	20	58	18
19	SIGN	1999	9,950		20	498	498	1,453	19
20	FENCE	1999	945		20	47	47	133	20
21	KITCHEN CIRCUITS	1999	439		20	22	22	62	21
22	SECURITY CAMERA	1999	1,175		20	59	59	167	22
23	SECURITY CAMERA	1999	600		20	30	30	85	23
24	CARPET	1999	530		20	27	27	72	24
25	LANDSCAPING CURB	1999	10,500		20	525	525	1,400	25
26	VINYL FLOOR	1999	990		20	50	50	133	26
27	OFFICE RECONSTRUCT	1999	9,895		20	495	495	1,155	27
28	DIFFUSERS & EXHAUST	1999	1,080		20	54	54	131	28
29	WALLGUARD	1999	4,311		20	216	216	522	29
30	CONDENSER FAN	1999	809		20	40	40	97	30
31	OFFICE JACKS	1999	605		20	30	30	68	31
32	ICE DISPENSER	1999			20				32
33	OFFICE RECONSTRUCRT	1999	685		20	34	34	79	33
34	TOTAL (lines 1 thru 33)		$ 7,042,589	$ 273,147		$ 210,792	$ (62,355)	$ 1,042,937	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,042,589	$ 273,147		$ 210,792	$ (62,355)	$ 1,042,937	1
2	CHILLER SYSTEM	1999	1,185		20	59	59	152	2
3	CHILLER SYSTEM	1999	607		20	30	30	75	3
4	SIGN	1999	2,173		20	109	109	245	4
5	CHILLER SYSTEM	1999	1,509		20	75	75	156	5
6	PARKING LOT	1999	1,075		20	54	54	122	6
7	REMODEL 2 BTHRM	2000	2,970		20	149	149	286	7
8	CANOPY COVER	2000	4,600		20	230	230	441	8
9	REPAIR WALK-IN COOLR	2000	915		20	46	46	92	9
10	AMERICAN HEALH CARE	2000	488		20	24	24	48	10
11	INSTLTN OF LANDSCAPG	2000	9,637		20	482	482	723	11
12	WALLCOVERING	2000	3,944		20	197	197	230	12
13	TILE	2000	2,267		20	113	113	141	13
14	SCREENS	2000	630		20	32	32	37	14
15	2ND FL IMPROVEMENT	2000	3,990		20	200	200	233	15
16	POWER OUTLET TO KITC	2000	435		20	22	22	26	16
17	WINDOW SHADES	2000	842		20	42	42	49	17
18	LANDSCAPING	2000	985		20	49	49	74	18
19	WALLCOVERING	2000	5,590		20	280	280	303	19
20	AWNING/WALL	2000	5,100		20	255	255	276	20
21	ELECTRICAL PANEL	2000	673		20	34	34	62	21
22	FREEZER	2000	520		20	26	26	52	22
23	WALLCOVERING	2000	(3,850)		20	(193)	(193)	(193)	23
24	LANDSCAPING	2000	(9,637)		20	(442)	(442)	(442)	24
25	AWNING	2001	3,960		20	198	198	198	25
26	DIAMOND PLATING	2001	792		20	40	40	40	26
27	WINDOW TREATMENTS	2001	912		20	46	46	46	27
28	WINDOW TREATMENTS	2001	1,525		20	76	76	76	28
29	DINING ROOM WALL	2001	8,000		20	333	333	333	29
30	FENCING	2001	1,558		20	59	59	59	30
31	3 DOORS	2001	1,272		20	53	53	53	31
32	FENCING	2001	1,558		20	52	52	52	32
33	LANDSCAPING	2001	10,652		20	311	311	311	33
34	TOTAL (lines 1 thru 33)		$ 7,109,466	$ 273,147		$ 213,833	$ (59,314)	$ 1,047,293	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,109,466	$ 273,147		$ 213,833	$ (59,314)	$ 1,047,293	1
2	CONDESOR FAN MOTOR	2001	842		20	25	25	25	2
3	SECURITY LOCKS	2001	767		20	22	22	22	3
4	WANDERGUARD	2001	569		20	16	16	16	4
5	PARKING LOT REPAIR	2001	1,375		20	35	35	35	5
6	ROOF TOP CHILLER REP	2001	904		20	23	23	23	6
7	PARKING LOT SEAL	2001	3,565		20	74	74	74	7
8	ROOF TOP CHILLER REP	2001	525		20	13	13	13	8
9	AWNING SYSTEM	2001	3,100		20	90	90	90	9
10	COMPRESSOR MOTOR	2001	874		20	15	15	15	10
11	PAINTING	2001	992		20	13	13	13	11
12	FLOW SWITCH	2001	630		20	21	21	21	12
13	ELECTRICAL	2001	4,620		20	116	116	116	13
14	ELECTRICAL	2001	897		20	4	4	4	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,129,126	$ 273,147		$ 214,300	$ (58,847)	$ 1,047,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 7,129,126	$ 273,147		$ 214,300	$ (58,847)	$ 1,047,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,129,126	$ 273,147		$ 214,300	$ (58,847)	$ 1,047,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 7,129,126	$ 273,147		$ 214,300	$ (58,847)	$ 1,047,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,129,126	$ 273,147		$ 214,300	$ (58,847)	$ 1,047,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 7,129,126	$ 273,147		$ 214,300	$ (58,847)	$ 1,047,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,129,126	$ 273,147		$ 214,300	$ (58,847)	$ 1,047,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 7,129,126	$ 273,147		$ 214,300	$ (58,847)	$ 1,047,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,129,126	$ 273,147		$ 214,300	$ (58,847)	$ 1,047,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 7,129,126	$ 273,147		$ 214,300	$ (58,847)	$ 1,047,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,129,126	$ 273,147		$ 214,300	$ (58,847)	$ 1,047,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated NuCare			1997	413	11	39	21	10	266	9
10	Allocated NuCare			1998	362	9	39	18	9	63	10
11	Allocated NuCare			1999	508	70	39	25	(45)	62	11
12	Allocated NuCare			2000	617	16	39	31	(15)	44	12
13	Allocated NuCare			2001	239	5	39	10	5	10	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,139	$ 111		$ 105	$ (36)	$ 445	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 557,777	$ 93,049	$ 56,139	$ (36,910)	10	$ 212,114	71
72	Current Year Purchases	63,717	675	2,599	1,924	10	2,599	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 621,494	$ 93,724	$ 58,738	$ (34,986)		$ 214,713	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	98 CHEVY VAN	2001	$ 11,532	$ 1,731	$ 480	$ (1,251)	5	$ 480	76
77										77
78										78
79										79
80	TOTALS			$ 11,532	$ 1,731	$ 480	$ (1,251)		$ 480	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,348,652	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 368,602	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 273,518	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (95,084)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,262,953	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Alloc. Nucare				8,453			5
6								6
7	TOTAL				$ 8,453 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 21,066 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility Van	98 Chevy Van	$ 625	$ 4,375	17
18					18
19					19
20					20
21	TOTAL		$ 625	$ 4,375	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	
COMMUNITY COLLEGE	X
HOURS PER AIDE	120

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	
HOURS PER AIDE	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 2,850	$	$ 2,850
2	Books and Supplies		461		461
3	Classroom Wages (a)		4,757		4,757
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 8,068	$	$ 8,068
10	SUM OF line 9, col. 1 and 2 (e)	$ 8,068			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 60,537	$		$ 60,537	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			10,521			10,521	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			67,392			67,392	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			170,583	3,376		173,959	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):			9,663			63,897		73,560	13
14	TOTAL			$ 9,663		$ 309,033	$ 67,273		$ 385,969	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 54,624	$ 58,405	1
2	Cash-Patient Deposits	5,124	5,124	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,274,812	3,274,812	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,719	56,719	6
7	Other Prepaid Expenses	11,652	11,652	7
8	Accounts Receivable (owners or related parties)	1,041,230	1,041,230	8
9	Other(specify): See supplemental schedule	185,285	185,285	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,629,446	$ 4,633,227	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		(140,468)	11
12	Long-Term Investments			12
13	Land		690,000	13
14	Buildings, at Historical Cost		6,879,664	14
15	Leasehold Improvements, at Historical Cost	506,641	506,641	15
16	Equipment, at Historical Cost	603,786	842,509	16
17	Accumulated Depreciation (book methods)	(521,735)	(1,816,873)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		178,393	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(106,966)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	2,301	249,439	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 590,993	$ 7,282,339	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,220,439	$ 11,915,566	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,057,930	$ 2,057,930	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,505	13,505	28
29	Short-Term Notes Payable	514,414	514,414	29
30	Accrued Salaries Payable	101,411	101,411	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,430	13,430	31
32	Accrued Real Estate Taxes(Sch.IX-B)	402,112	402,112	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	2,730,839	2,730,839	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,833,641	$ 5,833,641	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,498,449	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 7,498,449	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,833,641	$ 13,332,090	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,613,202)	$ (1,416,524)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,220,439	$ 11,915,566	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,915,524)	1
2	Restatements (describe):		2
3	See Attached	(241,394)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,156,918)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	543,716	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 543,716	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,613,202)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,743,014	1
2	Discounts and Allowances for all Levels	(614,023)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,128,991	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	707,172	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 707,172	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	289,312	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	62,954	19
20	Radiology and X-Ray	38,070	20
21	Other Medical Services	21,688	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 412,024	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,255	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,255	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	2,702	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,702	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,259,144	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,335,323	31
32	Health Care	2,268,475	32
33	General Administration	2,025,954	33
	B. Capital Expense		
34	Ownership	1,569,920	34
	C. Ancillary Expense		
35	Special Cost Centers	425,186	35
36	Provider Participation Fee	90,570	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,715,428	40
41	**Income before Income Taxes (line 30 minus line 40)****	543,716	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 543,716	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,989	2,086	$ 75,484	$ 36.19	1
2	Assistant Director of Nursing	1,935	2,091	54,141	25.90	2
3	Registered Nurses	12,138	13,196	383,453	29.06	3
4	Licensed Practical Nurses	28,797	31,066	542,194	17.45	4
5	Nurse Aides & Orderlies	72,200	75,930	671,724	8.85	5
6	Nurse Aide Trainees	547	547	4,757	8.70	6
7	Licensed Therapist	1,265	1,265	9,663	7.64	7
8	Rehab/Therapy Aides	2,265	2,456	41,396	16.86	8
9	Activity Director	1,970	2,086	30,637	14.69	9
10	Activity Assistants	7,774	8,252	65,402	7.93	10
11	Social Service Workers	3,584	3,761	49,573	13.18	11
12	Dietician	2,790	2,895	48,980	16.92	12
13	Food Service Supervisor	2,790	2,895	49,221	17.00	13
14	Head Cook	10,660	11,596	95,644	8.25	14
15	Cook Helpers/Assistants	15,710	16,849	118,155	7.01	15
16	Dishwashers					16
17	Maintenance Workers	2,896	3,040	55,092	18.12	17
18	Housekeepers	33,369	35,336	274,233	7.76	18
19	Laundry					19
20	Administrator	1,962	2,015	91,347	45.33	20
21	Assistant Administrator	3,084	3,234	93,315	28.85	21
22	Other Administrative	2,069	2,206			22
23	Office Manager					23
24	Clerical	19,086	21,275	245,079	11.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,890	1,992	29,467	14.79	31
32	Other Health Care(specify)					32
33	Other(specify)	1,335	1,335	39,217	29.38	33
34	TOTAL (lines 1 - 33)	232,101	247,402	$ 3,068,174 *	$ 12.40	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	6,266	$ 6,266	01-03	35
36	Medical Director	36,350	32,550	09-03	36
37	Medical Records Consultant	4,032	4,032	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	1,872	1,872	10-03	39
40	Physical Therapy Consultant	809	809	10a-03	40
41	Occupational Therapy Consultant	29	908	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	143	10a-03	43
44	Activity Consultant	4,164	4,164	11-03	44
45	Social Service Consultant	61	3,137	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	53,587	$ 53,881		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	693	$ 27,241	10-03	50
51	Licensed Practical Nurses	2,334	70,988	10-03	51
52	Nurse Aides	18	317	10-03	52
53	TOTAL (lines 50 - 52)	3,045	$ 98,546		53

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brent Fitzgerald (01/01/01-04/09/01)	Asst. Admin	None	$ 14,912
Dave Schecter (01/01/01-04/23/01)	Administrator	None	32,314
Charlie Ross (04/23/01-12/31/01)	Administrator	None	55,918
Colleen Kamin (12/11/01-12/31/01)	Administrator	None	3,115
See Attached Schedule			78,403
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 184,662

B. Administrative - Other

Description	Amount
Management Services (See Detail Attached)	$ 448,034
Management Fees (Carepath Health Network)	40,740
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 488,774

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 36,212
FR&R	Accounting	10,231
See Attached	Computer Consultant	12,686
Personnel Planners	Unemployment Consultant	1,911
Purchasing Plus	Purchasing Service	600
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 61,641

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,108
Unemployment Compensation Insurance	34,881
FICA Taxes	228,740
Employee Health Insurance	63,094
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	23,846
Union Health and Welfare	89,082
Dental Insurance	2,684
Payroll Taxes FUTA	10,702
Payroll Taxes Reimbursement	11,979
TOTAL (agree to Schedule V, line 22, col.8)	$ 537,116

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	11,090
Health Care Worker Background Check	2,350
(Indicate # of checks performed 235)	
Yellow Page Advertising	9,024
Licenses, Permits & Fees	1,235
See Attached Schedule	38,096
Less: Public Relations Expense	
Non-allowable advertising	
Yellow page advertising	(9,024)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 52,971

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,927
Allocated From Nucare	1,064
Allocated From Carepath	24
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,015

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number RENAISSANCE AT HILLSIDE # 0042176 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $8953**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **37,958** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **90,570**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ _____ Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100% In 1**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees